Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PAIN & RECOVERY CLINIC
6660 AIRLINE DR
HOUSTON TX 77076

Carrier's Austin Representative Box

Box Number 17

Respondent Name

CASTLEPOINT NATIONAL INSURANCE

MFDR Date Received

JULY 24, 2013

MFDR Tracking Number

M4-13-3110-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above dates of service were denied even though our facility obtained pre-authorization and the treatment was properly documented. Attached is the pre-auth letter confirming that the authorized codes match the billed codes that were denied by the carrier."

Amount in Dispute: $11,062.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2013 through April 2, 2013	Chronic Pain Management Program CPT Code 97799-CP	$11,062.50	$11,062.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for Division specific services.
3. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Issues

1. Did the requestor obtain preauthorization for the services in dispute?

2. Is the requestor entitled to reimbursement?

Findings

1. Review of the documentation submitted by the requestor finds that the insurance carrier denied the Chronic Pain using denial code 50 – "These are non-covered services because this is not deemed a 'medical necessity' by the payer." In accordance with 28 Texas Administrative Code §134.600(p)(10) chronic pain management programs require preauthorization. The requestor obtained preauthorization for the program as referenced by preauthorization approvals numbered 9954213 dated January 28, 2013 and 9976609 dated March 21, 2013. According to 28 Texas Administrative Code §134.600(c)(1)(B) the insurance carrier is liable for all reasonable necessary medical costs relating to services in dispute that were approved prior to the services being provided. Therefore, the respondent's denial is not supported and the disputed services will be reviewed in accordance with Division rules and the Labor Code.
2. In accordance with 28 Texas Administrative Code §134.204(h)(5)(B), reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. Review of the submitted documentation finds that the services were rendered as billed. The requestor is due reimbursement as follows:
   - 88.50 hours of Chronic Pain Management x $125.00/hour = $11,062.50.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $11,062.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $11,062.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 3, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.